BURLEIGH DENTAL STUDIO

07 5576 6208 | burleighdentalstudio.com.au
3/109 West Burleigh Road, Burleigh Heads QLD 4220

NEW PATIENT MEDICAL HISTORY FORM

At Burleigh Dental Studio we strive to provide you with the highest standard of dental care. To ensure we can provide the best and safest care, we need to collect personal and medical details from you. Please be assured that this information is kept strictly confidential and maintained in accordance with State and Federal Privacy Legislation.

How did you hear about us?

- ☐ Professional recommendation
- ☐ GP referral
- ☐ Google / Website
- ☐ Marketing:
- ☐ Recommended by a friend:
- ☐ Facebook / Instagram
- ☐ Signage of the Practice
- ☐ Health Fund recommendation

If so, what? ……

Who may we thank for referring you? ……

Title:	Surname:	First Name:
Preferred Name:		DOB:
Residential Address: Suburb: Postcode:		Phone (Mobile): Phone (Home):
Email:		Occupation:
Contact Preference for Appointments (Circle): SMS Telephone Email		
Emergency Contact Person (Name/Phone):		
Do you have Private Dental Insurance? Yes No		Name of Fund:
Medicare Number:	Position:	Veterans Affairs Card Number:

MEDICAL HISTORY

Name of your General Practitioner:	Phone / Practice Name:
1. Are you currently taking any medications or tablets (including herbal supplements, bisphosphonates & blood thinners)?	
2. Are you allergic to any drugs/medications (including latex)?	
3. Are you currently undergoing any medical treatment?	
4. Have you been hospitalised in the last 12 months?	
5. Have you been advised to take antibiotics before dental appointments in the past?	
6. Have you had any abnormal reactions to local or general anaesthetic?	
7. Are you pregnant or breastfeeding?	
8. Do you smoke (Circle)? No Yes, _____ years?	Have you ever smoked (Circle)? No Yes, _____years ago?

Have you had or are you suffering from any of the following (please tick)?

Heart (Surgery, Disease, Attack)		Excessive or Prolonged Bleeding		Radiation or Chemotherapy	
Heart Pacemaker or Artificial Heart Valve		Sinus Troubles or Hay Fever		Cancer	
Stroke		Diet (Special/Restricted/Intolerances)		Thyroid Problems	
Prosthetic Implant or Joint Replacement		Stomach Ulcers or Reflux		Asthma	
Osteoporosis or Bone Disorders		Hepatitis (A/B/C)		Bronchitis, Emphysema or Lung Disease	
Tuberculosis		HIV/AIDS		Arthritis	
Diabetes		Rheumatic Fever		High/Low Blood Pressure	
Fainting or Dizzy Spells		Liver or Kidney Disease		Nervous Disorders (ADD, ADHD)	
Epilepsy or Seizures		Anaemia, Leukaemia or Blood Diseases		Sleep Apnoea	
Other (Please specify):					

DENTAL HISTORY

Reason for today's visit? .....

When was your last dental appointment? .....

Do you think you grind or clench your teeth during the day or when sleeping? .....

Do you feel nervous about dental treatment (Circle)? No Slightly Moderately Petrified

Are you concerned about or experiencing any of the following dental problems (please tick)?

Unhappy with appearance of your teeth		Food trapping between your teeth		Clicking/pain in the jaw joints	
Sensitivity to hot/cold or when eating		Staining of your teeth		Discoloured fillings	
Bleeding gums		Bad breath		Roughness of existing fillings	

Are you concerned with (please tick)?

Existing crowns, bridges, implants or dentures		Ability to eat		Silver/metal fillings	
Colour of your teeth		Missing teeth		Brushing/flossing technique	
Crooked teeth		Gaps between your teeth		Previous dental treatment	

CONSENT FOR TREATMENT & COMMUNICATION

- I am happy to receive SMS, Telephone and Email communication from Burleigh Dental Studio for appointment reminders and other information pertaining to oral health awareness, health fund or government changes.
- I hereby consent to dental treatment deemed necessary by the dentist and agreed by my verbal consent beforehand to be carried out. I understand that it will be discussed with me before any local anaesthetic, x-rays, study models, photographs or diagnostic aids are performed by the dentist to make a thorough assessment and diagnosis.
- Dental photographs are commonly taken to assist in the provision of your treatment as well as for patient education and oral health professional teaching. If you do not consent for your photos to be shared, please cross out this dot point and initial.
- I agree to be responsible for the payment of all services rendered on my behalf and on the behalf of my dependents and understand that payment is to be made at the time of my appointment.
- I understand that if I need to reschedule or cancel my appointment, I will give Burleigh Dental Studio 48 hours notice. If I fail to give 48 hours notice, a cancellation fee will apply.

Patient/Guardian's Name: ..... **Signature**: ..... **Date**: .....